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ABSTRACT

This paper discusses two paradigms which shape the policies and programs involved in the provision of professional services for parents and children. The paradigm identified as most influential in this area in the past is characterized as incorporating an individualistic, pathological perspective. The programs associated with this paradigm are described as emphasizing: (1) provision of services to the isolated individual; (2) contribution of professionals within their own institutions; and (3) treatment, amelioration, or remediation of deficiencies and deviations. The possibility that this paradigm may be counter-productive to child and family mental health is discussed and relevant research is cited. The new paradigm which is emerging from research on parents and children is characterized as a socio-ecological, developmental paradigm. Programs developed under the influence of this paradigm are described as emphasizing: (1) delivery of services within a family, community, and cultural context; (2) strengthening and supporting of family and community interaction; and (3) identification, development, and reinforcement of strengths, skills, and adaptive behaviors. Sources contributing to the development of this paradigm are identified and strategies for implementing a socio-ecological paradigm in the human service professions are discussed. (JMB)

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PROFESSIONAL PARADIGMS IN PROGRAMS FOR PARENTS AND CHILDREN

I. An Individualistic, Pathological Paradigm

II. A Socio-ecological, Developmental Paradigm

Earl S. Schaefer

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Scientific disciplines are guided by implicit theories, methods and perspectives that Kuhn (1970), in The Structure of Scientific Revolutions, has labelled paradigms. Kuhn suggests that accumulating research findings that cannot be explained by the old theory may lead to a crisis in the dominant paradigm and to development of new paradigms. Similarly, Whitehead (1958) has suggested that new ideas lead to new technologies and Reich (1970) has noted that a new consciousness can contribute to the development of new structures.

Not only do paradigms and perspectives influence the scope and focus of research in the social and health sciences, but they also influence professional services for parents and children (Schaefer, 1976). Recently, increasing awareness of problems in these services and accumulating research on parents and children are both clarifying the implicit existing perspectives and contributing to the development of new perspectives and a new paradigm.

Kuhn has noted that when old solutions to problems fail, a search for new solutions begins, first by following the rules of the existing paradigm and then through divergent approaches. In the field of education, when it was found that the schools were not achieving "Equality of Educational Opportunity" (Coleman, 1966), the search for solutions included preschool education and infant education, both guided by the existing professional-institutional approach. These "solutions" were followed by the increasingly divergent

approaches of child-centered, home-based infant education (Schaefer & Aaronson, 1976) and parent-centered home intervention (Levenstein, 1970). On a more general level, increasing awareness of the importance of the child's early experience in the home for his intellectual development and academic achievement (Hunt, 1961) and of the effectiveness of parent-centered intervention has led to recommendations of a life-time and life-space approach to education (Schaefer, 1971) and of a program of ecological intervention (Bronfenbrenner, 1973).

Divergent approaches and new perspectives are also emerging in the field of medicine. This is seen in pediatrics by recognition of the need to design and provide maternity care to promote mother-infant bonding (Klaus, et al., 1972; Lozoff, et al., 1977) rather than for the isolated mother and infant. In the health field, awareness of the need to promote high level wellness through modification of life styles and behavior patterns and new directions in planning in both Canada and the U.S. are also contributing to a re-evaluation of the existing paradigms.

What has been the major paradigm in the professions providing services for parents and children? Students in clinical psychology during the post World War II era learned that the fifty-minute hour of psychotherapist-client interaction was the major focus of mental health. Similarly, the teacher-pupil relationship was seen as the major focus in education and the doctor-patient relationship as the major focus in health. The common characteristics of these models are:

an individualistic perspective of providing services to the isolated individual; a professional-institutional perspective emphasizing the contribution of the professional, typically within his own institution, and; a pathological perspective emphasizing treatment, amelioration, or remediation of deficiences and deviations.

What are the characteristics of the new perspective or paradigm that is emerging from research on parents and children? They are: a socio-ecological perspective of delivery of services within a family, community, and cultural context as contrasted to the individualistic perspective of delivery of services to isolated individuals; a family and community perspective of strengthening and supporting family and community interaction as contrasted to the professional-institutional perspective of direct care to the isolated individual by the professional in an institution; and a developmental perspective of identifying, developing, and reinforcing strengths, skills, and adaptive behavior as contrasted to the pathological perspective of screening, diagnosis, treatment, remediation and prevention of specific pathologies.

The existing paradigm's individualistic emphasis on the delivery of services to the isolated individual has influenced the development of research, professional education, and service programs. This can be seen in conceptualization and measurement which typically focus upon the individual as an isolated entity, rather than upon his environment or his interaction with his environment. Diagnosis is likewise made by studying the individual apart from his environment, although Sullivan (1931) stated concerning psychiatry that,

"to isolate its individual subject matter, a personality, from a complex of interpersonal relations. . . is preposterously beside the point."

The delivery of medical as well as psychotherapeutic services is often to the isolated individual, although Bowlby (1951) has pointed out the folly of separating the child from his parents in the hospital and Klaus, et al. (1976) have pointed out the folly of separating the infant from his parents at birth.

Separation of the child from his family, community and culture, a common practice in Indian Education, could only be supported by an individualistic perspective. Yet, increasing understanding of the importance of the mother-child, father-child, and mother-father relationships for the well-being of the child (Schaefer, 1975) supports a socio-ecological perspective of strengthening and supporting the child's experiences in his natural environment.

Inseparably related to the existing paradigm's individualistic perspective is the emphasis on the importance of the professional's role in the care of the child, preferably in an institution such as a hospital, clinic, school or day-care center. Emphasis on the one-to-one relationship of the psychotherapist-patient, doctor-patient, or teacher-child stresses the professional's skills in supplementing and remediating the child's natural environment. Such an emphasis has often led to exclusion of the parent from the hospital, of the father from the delivery room and of parents from the infant nursery and the school. Thus, the professional-institutional perspective has typically neglected and occasionally supplanted the contribution of the family and the community in child care and education.

Perhaps as in a typical figure-ground contrast, concentration on the figure or the role of the professional has led to ignoring the ground or the major contribution of the family to the child's development. Yet, contrasting the parental role with the professional role on the child care characteristics of priority, duration, continuity, amount, extensity, intensity, pervasiveness, consistency, responsibility and variability suggests that the professions and institutions are unable to substantially replace parents in the care of children (Schaefer, 1972). Therefore, a perspective that emphasizes strengthening and supporting the role of family and community in child care is essential to complement the current emphasis on professional and institutional care of children.

A pathological perspective is another characteristic of the existing paradigm. Services are frequently initiated to treat, remediate, or prevent specific pathologies, i.e., symptoms, deviations, distortions and deficiencies in child development. Thus, the professional-institutional approach to child care focusses upon screening, diagnosis, treatment or prevention of specific pathologies rather than upon fostering health, growth and development. However, recent planning for health programs is increasingly emphasizing health rather than illness and development of life styles and behavior that promote health and "a high level of well-being."

In the behavioral sciences and human service professions, professionals such as psychiatrists and clinical psychologists who have responsibility for coping with illness focus more upon identification of pathology as part of the diagnosis and treatment process than do professionals such as pediatricians and developmental psychologists

who have more responsibility for promoting health and development. Perhaps for that reason, conceptualization, measurement and research in mental health often focus upon identifying symptoms, deficiencies, and deviant behavior, rather than upon identifying strengths, skills, competence, adaptive behavior, and social and emotional adjustment. If one were to compute the proportion of positive and negative behaviors in many of our inventories, rating scales, case histories, and other conceptualizations of mental health, a high, occasionally exclusive, emphasis upon pathology would be found.

Is it possible that the pathological focus in mental health and human service professions may be counter-productive of child and family mental health? A focus upon identifying pathology and mental illness may have effects similar to those of identifying witches in colonial Salem or of parents identifying and punishing wickedness in children.

Research shows that parental beliefs that children are naturally bad and will be bad unless forced to be good are negatively correlated with children's adaptive behavior (Schaefer, et al., 1969). Positively correlated with children's adaptive behavior are parents' positive perceptions of their children (Schaefer & Bayley, 1963; Broussard & Hartner, 1970). Baer, et al. (1976) have found that instructing parents to count their responses to their children's positive behavior results in increases in positive behavior and decreases in maladaptive behavior. Similarly, a prescriptive approach that fosters the

development of positive behavior has a more favorable effect upon child development than a proscriptive approach that attempts to eliminate negative behavior (McKinney, 1971; Olejnik & McKinney, 1977). The danger with concepts and measures that encourage parents to identify and respond to pathological behavior is that they may fail to refocus parents' attention upon positive development.

Although it might be difficult for many clinicians and behavioral scientists to abandon their diagnostic and pathological behavior concepts, a synthesis between a focus upon pathology and upon positive behavior might be achieved through conceptualization and measurement of bipolar dimensions of child behavior. An emphasis upon development, identification and reinforcement of altruistic, loving behavior might be encouraged by a bipolar dimension contrasting considerate behavior with anti-social, aggressive, delinquent behavior. The hyperactivity and distractibility that are often associated with learning disabilities might be contrasted with persistence, concentration and attention. Similarly, the anxiety, withdrawal, and inhibition that are associated with neurotic behavior might be contrasted with expressive, gregarious, cheerful behavior. In general, both parents and clinicians might emphasize developing positive behaviors as the major method of reducing negative ones (Schaefer, 1971).

Different paradigms lead to different priorities and goals in the human service professions. The individualistic perspective emphasizes fostering autonomy and individual development, whereas the socio-ecological perspective of the emerging paradigm emphasizes strengthening and supporting family and community interaction and

involvement. The existing paradigm's professional and institutional perspective supplements and, at times, inadvertently supplants family care of the child, while the new perspective emphasizes family and community care of the child. Finally, the pathological perspective emphasizes the responsibility of the professions for coping with pathology through screening, diagnosis and treatment, whereas the emerging paradigm's developmental perspective places emphasis on fostering health, competence, and adjustment throughout the child's entire life time and life space.

What are the sources contributing to the development of a new paradigm for human services? During the 1960's, there was an increasing awareness of the environment's importance in intellectual development (Hunt, 1961) and of the early stabilization of levels of intellectual functioning (Bloom, 1964). This led to recognition of the need for early and continuing education (Schaefer, 1971). In addition, an increasing recognition of the importance of the parent's role in the child's intellectual development (Hess, 1969; Schaefer, 1972) indicated the need for a life-time and life-space approach to education and child development.

Child-centered intervention research demonstrated that early intervention could produce short-term increases in mental test scores, but long-term follow-ups often found that early gains were not maintained without continuing intervention (Schaefer, 1972; Bronfenbrenner, 1974). However, parent-centered interventions appeared to have equal short-term effects and greater long-term effects upon child development (Bronfenbrenner, 1974). Thus, the accumulating evidence of the importance

of the child's early experience and of the major role of the family environment for his continuing education (Coleman, 1966) has suggested the need to complement the professional-institutional approach to education with a socio-ecological, developmental approach emphasizing the child's interaction with his environment.

Research on parent influence upon child development and upon parent-centered intervention has contributed to the development of the Home Start Program and the implementation of Home Start as an option within Head Start. In addition, the Parent and Child Centers Program and the Child and Family Resource Program in the Office of Child Development are increasingly utilizing family and community based approaches, rather than those providing direct professional care and education to the isolated child in an institutional setting.

Research on the effects of separation of mother and infant at the time of delivery has contributed to a paradigm shift in maternal and child health. The existing paradigm--emphasizing the health of the isolated, individual mother and infant, and the importance of the physician's and hospital's role and of preventing illness--has led to maternity care policies that provide little contact between mother and infant and even less involvement of the father during the hospital stay. However, evidence that mother-infant separation may impair maternal attachment to the infant and may have negative effects upon maternal care (Klaus, et al., 1972; Klaus & Kennel, 1976) has contributed to a re-evaluation of professional and institutional policies and practices and to a resurgence in family centered maternity care. Interest in parent-centered intervention and research on parent-physician interaction in child health are growing (Schaefer & Siegel, 1976).

Despite the growth of programs reflecting the new perspective, many health and education programs and practices still emphasize the individualistic, professional and institutional perspective as their major approach to child health, education and development. For example, recommendations of preschool and day care for all children are often motivated by the belief that child development can best be achieved through professional care and education. However, growing awareness of the cost of infant day care and of hospital and institutional care, as well as questions about the effectiveness of these measures (Bronfenbrenner, 1976) has increased the attractiveness of strengthening and supporting family care of children.

The need for development of effective methods of supporting parental care still limits rapid growth in programs guided by a socio-ecological, developmental perspective. Funds and manpower are necessary to implement a new paradigm through research, development, evaluation, and training of personnel. Perhaps, legislators, the public, and professionals who are still seeking solutions through professional-institutional approaches are not aware of these needs.

Clearly, we have a choice between an exclusive focus upon building and staffing institutions that supplement and supplant family care or of developing a system that strengthens and supports family, extended family and community care of children. Examination of professional training programs and budget appropriations reveals that the individualistic, professional-institutional paradigm still dominates planning for human service programs. Likewise, an examination of scientific journals in the behavioral sciences as to the extent to which they

promote an individualistic rather than a socio-ecological perspective, a pathological rather than a developmental conceptualization, and brief direct interventions rather than long-term, ecological interventions, indicates the need to change both the scope and focus of current research (Schaefer, 1976).

What strategies might be used to implement a socio-ecological paradigm in the human service professions? First, a knowledge basis for the new paradigm must be established. Needed are; new conceptualization and measurement methods, new cross-sectional and longitudinal research establishing a basis for new programs and policies, and development and evaluation of service programs to determine their cost effectiveness.

More specifically, funding for the development of a knowledge basis for effective implementation should be accompanied by the development of government policies and programs providing incentives for professional and institutional change. Funding is needed for program implementation and for evaluation of innovative programs within health and education institutions as well as for programs in university research centers. Although the Office of Child Development has begun to implement the findings of intervention research through demonstration programs and through Head Start, schools have not mobilized the money and manpower required.

In order to shift the focus of the professions and institutions, new university curricula and new training programs are required to prepare professionals with new perspectives and skills needed for different roles and responsibilities. For example, many educators have little knowledge of the parent's role in the child's education

and little preparation for work in education for parenthood and parent education. Establishment of family studies programs for future professionals and of university family research centers are possible strategies.

Legislation, funding, conventional professional roles and responsibilities and well-established policies and practices are difficult to change. Increased professional awareness of both the implicit paradigm that influences human service programs and of a new paradigm that might contribute to the development of new services would increase the rate of change. Use of the mass media to develop consciousness of the family's and community's role in child development and of the need for a new partnership among parents and professionals might also be effective. Such efforts may result in consumer demands for the development of new health and education programs as has been true in the development of family-centered maternity care.

An ecological perspective on the child's health, education and welfare suggests the need for renewed emphasis on parent education and education for parenthood. A fourth "R" for Rearing might be added to the basic curriculum for all children throughout the school years rather than for a few adolescents who take a high school course in family life education or education for parenthood. Or, perhaps the suggestion that the fourth "R" be Relating--including relating to children, husbands or wives, friends, neighbors and professionals--might promote a socio-ecological approach by training future parents for cooperation and collaboration in the rearing of children. In addition, a renewed emphasis on parent education, with ample support

for research, development and evaluation, might provide training and support for parents throughout the period of child rearing from infancy to maturity.

In conclusion, the current roles of professions and institutions in child care should be integrated into a comprehensive system that includes a major focus upon the contribution of family and community, as well as upon the role of the professions and institutions. In the past, the family and community had responsibility for child care, health, education and welfare. With the rapid growth of the professions and institutions, there has been increasing supplementation and, occasionally, supplantation of family care, but little integration of family and community care with that of professionals. A new synthesis is needed in which the professions and institutions strengthen and support the family and community, supplement family care when necessary but avoid activities that might weaken or supplant it.

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